

ILLINOIS CARNIVAL & AMUSEMENT RIDE DIVISION - ACCIDENT REPORT

Fax this form to (217)782-0596

| | | | |
|---|--|---|---|
| Name of Amusement Company or Park | | Owner Name | |
| Address | | Phone # | |
| City/State/Zip | | Operator Name | |
| Date of Accident | | Time | Permit # |
| Ride/Attraction Name | | Manufacturer of Ride | |
| Event Name: | | Event Location: | |
| Operator Training on File: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Did accident occur on ride? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Describe fully how accident occurred and state what injured was doing when the accident occurred: | | | |
| INJURED PATRON INFORMATION (please print) | | | |
| Did accident cause a fatality? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Did accident require treatment by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Did accident require first aid? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Name of hospital or care facility: | |
| Injury as described by injured party: | | How was patron transported? | |
| Nature of injury and treatment: | | | |
| Name of Injured: | | Age: | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address/City/State: | | | |
| Phone #: | | Diagnosis: | |
| WITNESS INFORMATION (please print) Use additional sheet if required. | | | |
| Witness Name: | | | |
| Address: | | | |
| City/State/Zip: | | Phone #: | |
| Witness Name: | | | |
| Address: | | | |
| City/State/Zip: | | Phone #: | |

Name of Owner/Agent Completing Report (PRINT) _____

Signature of Person Completing Report _____

Signature Date _____